Secretary for Health and Family Services Selections for Preferred Products

This is a summary of the final Preferred Drug List (PDL) selections made by the Secretary for Health and Family Services based on the September 17, 2009 Pharmacy and Therapeutics Advisory Committee (PTAC) Meeting.

Description of Recommendation	P & T Vote	Final Decisions (s)
Branded Products with Generic	Passed	The following products will require prior
Components	8 For	authorization
Require prior authorization for the following	0 Against	• IC400 [®]
products:	1 Abstention	• IC800®
• IC400®		Benziq [®]
• IC800®		_
Benziq [®]		
New Drugs to Market: Lamictal XR TM	Passed	Lamictal XR [™] will be placed preferred in the PDL
Place this product preferred in the PDL	7 For	category titled: Anticonvulsants: Second
category titled: Anticonvulsants: Second	1 Against	Generation.
Generation.	1 Abstention	
New Drugs to Market: Multaq®	Passed	Multaq® will pay as preferred until it can be
Allow this product to pay as preferred until it		reviewed at the next PTAC meeting when the
can be reviewed at the next PTAC meeting	0 Against	Committee's Cardiologist is present.
when the Committee's Cardiologist is present.		
New Drugs to Market: Cetraxal TM	Passed	Cetraxal™ will be placed non preferred in the PDL
Place this product non preferred in the PDL	9 For	category titled: Otic: Quinolone Antibiotics.
category titled: Otic: Quinolone Antibiotics.	0 Against	(A)
New Drugs to Market: BenzaClin	Passed	BenzaClin CareKit® will be placed non preferred in
<u>CareKit[®]</u>	9 For	the PDL category titled Dermatologics: Antibiotic
Place this product non preferred in the PDL	0 Against	Agents for Acne.
category titled Dermatologics: Antibiotic		
Agents for Acne.		
New Drugs to Market: Nucynta TM	Passed	Nucynta TM will be placed non preferred in the PDL
Place this product non preferred in the PDL	9 For	category titled: Narcotics: Short-Acting.
category titled: Narcotics: Short-Acting.	0 Against	

Description of Recommendation	P & T Vote	Final Decisions (s)	
New Drugs to Market: Edluar®	Passed	Edluar® will be placed non	preferred in the PDL
Place this product non preferred in the PDL	9 For	category titled: Sedative Hy	
category titled: Sedative Hypnotic Agents	0 Against	following clinical criteria:	
with the following clinical criteria:	0118		
With the following emilient effective.		Edluar® will be approved if	f one of the following
Edluar® will be approved if one of the		criteria is met:	
following criteria is met:		 Diagnosis of dyspl 	hagia via an ICD-9
• Diagnosis of dysphagia via an ICD-9		Override, OR	_
Override, OR			
		Diagnosis	ICD-9 Code
Diagnosis ICD-9 Code		dysphagia	787.2
dysphagia 787.2		dysphagia - functional,	
dysphagia - functional,		hyseterical, or nervous	300.11
hyseterical, or nervous 300.11		dysphagia - psychogenic	306.4
dysphagia - psychogenic 306.4		dysphagia - sideropenic	280.8
dysphagia - sideropenic 280.8		dysphagia - spastica	530.5
dysphagia - spastica 530.5			
		• Trial and failure of 2	
 Trial and failure of 2 preferred 		hypnotics, one of wh	ich must be zolpidem.
sedative hypnotics, one of which must			
be zolpidem.			o 1: 1 DDI
New Drugs to Market: Adcirca TM	Passed	Adcirca™ will be placed no	
Place this product non preferred in the PDL		category titled: Age	
category titled: Agents for Pulmonary		Hypertension with the follow	ving clinical criteria:
Hypertension with the following clinical	1	Adcirca™ will be approved	if both of the following
criteria:		criteria are met:	n bom of me following
A 1 : TW : 11 1 1 : f both of the			ary hypertension via an
Addireca TM will be approved if both of the		Diagnosis of pulmon ICD-9 Override (416)	
following criteria are met:		•	sildenafil via a 90 day
• Diagnosis of pulmonary hypertension via an ICD-9 Override (416.0, 416.8),		electronic look back.	
AND		Ciconome rook back.	
• Trial and failure of sildenafil via a 90	,		
day electronic look back.			
New Drugs to Market: Acuvail TM	Passed	Acuvail TM will be placed no	n preferred in the PDL
Place this product non preferred in the PDL	1	category titled: Ophthalmic	
category titled: Ophthalmic NSAIDs.	0 Against		
New Drugs to Market: Efficient TM	Passed	Effient TM will pay as preferr	ed until it can be
Allow this product to pay as preferred until it	9 For	reviewed at the next PTAC	meeting when the
The same that th			
can be reviewed at the next PTAC meeting	0 Against	Committee's Cardiologist is	present.

Description of Recommendation	P & T Vote	Final Decisions (s)
Protein Tyrosine Kinase Inhibitors	Passed	Selected Preferred Agent (s)
1. DMS to select preferred agent(s) based on	9 For	Gleevec [®]
economic evaluation; however, at least	0 Against	
imatinib should be preferred.		
2. Agents not selected as preferred will be		
considered non preferred and require PA		
via a 90 day electronic look back.		
3. All agents in the category will have no		
higher than a tier 2 copay regardless of		
PDL status.		
4. DMS to allow continuation of therapy for		
existing users of non preferred products		
via a 90 day look back.		
5. For any new chemical entity in the Protein		
Tyrosine Kinase Inhibitor class, require a		
PA until reviewed by the P&T Advisory		
Committee.	D 1	Downwall the approved if the nation
Ranexa® Clinical Criteria	Passed 9 For	Ranexa [®] (ranolazine) will be approved if the patient has a history of one agent in any of the following
Ranexa [®] (ranolazine) will be approved if the patient has a history of one agent in any of the	0 Against	drug classes within the past 90 days (unless ALL
following drug classes within the past 90 days	0 Agamst	are contraindicated).
(unless ALL are contraindicated).		Beta Blocker
Beta Blocker		Nitrate
Nitrate		Calcium Channel Blocker
Calcium Channel Blocker		Calcium Chamier Blocker
Lidoderm® Clinical Criteria	Passed	Lidoderm® will be approved if any one of the
Lidoderm will be approved if any one of the	9 For	following criteria are met:
following criteria are met:	0 Against	Diagnosis of Post Herpetic Neuralgia via an
Diagnosis of Post Herpetic Neuralgia	0 7 Edinst	ICD-9 override; OR
via an ICD-9 override; OR		History of one agent in any of the following
History of one agent in any of the		medication classes in the past 90 days:
following medication classes in the		o Tricyclic antidepressant
past 90 days:		o Anticonvulsant
o Tricyclic antidepressant		o SNRI
o Anticonvulsant		
o SNRI		

Description of Recommendation	P & T Vote	Final Decisions (s)
Hepatitis C: Pegylated Interferons	Passed	Selected Preferred Agent (s)
1. Rename the category Hepatitis C:	9 For	PEGASYS®
Interferons.	0 Against	PEGASYS® Convenience pack
2. DMS to select preferred agent (s) based on		PEG-Intron TM
economic evaluation; however, at least		PEG-Intron™ Redipen
peginterferon alfa-2a and peginterferon		
alfa-2b should be preferred.		
3. Agents not selected as preferred will be		
considered non preferred.		
4. PDL selected agents will apply for any new		
courses of therapy only.		
5. All agents in the category will have no		
higher than a tier 2 copay regardless of		
PDL status.		
6. Place clinical prior authorization around		
the entire class to ensure appropriate		
utilization.		
7. For any new chemical entity in the		
Hepatitis C: Interferons class, require a PA		
until reviewed by the P&T Advisory		
Committee.		

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D 1/2 CD 3/2	D 0 /T X7.4.	Final Decisions (c)
Description of Recommendation	P & T Vote	Final Decisions (s)
Hepatitis C: Pegylated Interferons Clinical	Passed	All preferred and non-preferred pegylated
<u>Criteria</u>	9 For	interferons will require a prior authorization after
All preferred and non-preferred pegylated	0 Against	the initial 16 weeks of therapy.
interferons will require a prior authorization		AC (1 14 14 1 C)
after the initial 16 weeks of therapy.		After the initial 16 weeks of therapy pegylated
		interferons will be approved if:
After the initial 16 weeks of therapy		1. HCV RNA Assay results obtained prior to
pegylated interferons will be approved if:		initiation of therapy AND 12 weeks after
1. HCV RNA Assay results obtained		initiation of therapy must be provided. If
prior to initiation of therapy AND 12		the difference between the two assays is at
weeks after initiation of therapy must		least a 2 logarithmic unit decrease (example:
be provided. If the difference between		from 2,000,000 IU to 20,000 IU), THEN
the two assays is at least a 2		approve for duration of therapy as defined
logarithmic unit decrease (example:		below.
from 2,000,000 IU to 20,000 IU),		2. If the assays were done BUT the difference
THEN approve for duration of		between the two assays WAS NOT at least
therapy as defined below.		a 2 logarithmic unit decrease (example:
2. If the assays were done BUT the		from 2,000,000 IU to 20,000 IU), THEN
difference between the two assays	*	refer the request to a clinical pharmacist
WAS NOT at least a 2 logarithmic		who will deny the request.
unit decrease (example: from		3. If there is any other valid medical reason
2,000,000 IU to 20,000 IU), THEN		why the patient should require this therapy,
refer the request to a clinical		a clinical pharmacist may approve the
pharmacist who will deny the request.		request for the total length of therapy as
3. If there is any other valid medical		listed below.
reason why the patient should require		A TRATE ARTION ON A PRICERIO OF WITCH ADVICE
this therapy, a clinical pharmacist may		LIMITATION ON LENGTH OF THERAPY IS
approve the request for the total length		BASED ON PRODUCT
of therapy as listed below.		1. Interferon alfacon-1
		a. IFN naïve – 24 weeks total therapy
LIMITATION ON LENGTH OF THERAPY		b. INF relapse – 48 weeks total therapy
IS BASED ON PRODUCT		2. Peginterferon alfa-2a OR 2b
1. Interferon alfacon-1		a. Genotype 1, 4, age 2-17 years, OR HIV
a. IFN naïve – 24 weeks total therapy		positive – 48 weeks total therapy
b. INF relapse – 48 weeks total therapy		b. Genotype 2, $3-24$ weeks total therapy
2. Peginterferon alfa-2a OR 2b		
a. Genotype 1, 4, age 2-17 years, OR		
HIV positive – 48 weeks total therapy		
b. Genotype 2, 3 – 24 weeks total		
therapy		

Description of Recommendation	P & T Vote	Final Decisions (s)
Hepatitis C: Ribavirins	Passed	Selected Preferred Agent (s)
1. DMS to select preferred agent (s) based	9 For	ribavirin
on economic evaluation; however, at	0 Against	Ribapak [™]
least ribavirin should be preferred.		Ribasphere™
2. Agents not selected as preferred will be		
considered non preferred.		
3. PDL selected agents will apply for any		
new courses of therapy only.		
4. Place clinical prior authorization around		
the entire class of ribavirins to ensure		
appropriate utilization.		
5. For any new chemical entity in the		
Hepatitis C: Ribavirins class, require a		
PA until reviewed by the P&T Advisory		
Committee.		
Hepatitis C: Ribavirins Clinical Criteria	Passed	Ribavirins will pay at point-of-sale if there is
Ribavirins will pay at point-of-sale if there is	9 For	concurrent interferon therapy in history.
concurrent interferon therapy in history.	0 Against	

Description of Recommendation	P & T Vote	Final Decisions (s)
Antihyperkinesis Agents	Passed	Selected Preferred Agent (s)
1. DMS to select preferred agent(s) based on	9 For	dexmehtylphenidate IR
economic evaluation; however, at least	0 Against	dextroamphetamine IR
one sort-acting, one intermediate-acting		dextroamphetamine ER
and one long-acting formulation of		methylphenidate IR
methylphenidate and dextroamphetamine		methylphenidate SA/SR
as well as atomoxetine should be		mixed amphetamine salts IR
preferred.		Adderall® XR
2. Agents not selected as preferred will be		DextroStat [®]
considered non preferred and require trial		Focalin TM XR
and failure of one preferred product,		Metadate [®] CD
preferred generics must be tried before		Metadate [®] ER
multisource branded products will be		Methylin® (tablets, chewable tablets)
approved.		Methylin [®] ER
3. Require appropriate ICD-9 on all		Strattera [®]
prescriptions for agents within this class.		Vyvanse [™]
4. Continue to require prior authorization for		
modafinil and armodafinil to ensure		
utilization in FDA-approved indications		
only.		
5. Place quantity limits on all agents based		·
on the American Academy of Child and		
Adolescent Psychiatry and FDA-		
approved maximum recommended dose.		
6. Allow only one agent at a time for an		
extended release product and one agent at		
a time for an immediate release product		
unless switching agents due to therapeutic		
failure.		
7. Allow continuation of therapy for non		
preferred products via a 90 day look back.		
8. For any new chemical entity in the		
Antihyperkinesis class, require a PA until		
reviewed by the P&T Advisory		
Committee.		

Description of Recommendation		
Antihyperkinesis Agents Clinical Criteria		
Diagnosis to Approve via an ICD-9 Override:		

Diagnosis	ICD-9
Attention	314.1
Deficit/Hyperreactivity	314.01
Disorder (ADHD)	314.2
	314.8
	314.9
Attention Deficit Disorder	314.00
(ADD)	
Narcolepsy	347.00
	347.01
	347.11
Sleep apnea/hypoapnea	780.57
syndrome	780.51
	780.53
Shift work sleep disorder	307.45

^{**}Agents may be approved for other diagnosis via the prior authorization process based on a review of the current literature by a clinical pharmacist.

Quantity Limits/Maximum Daily Dose

- Adderall® 60 mg per day
- Adderall[®] XR 60 mg per day
- Concerta[®] 108 mg per day
- Daytrana[™] 30 mg per day
- Desoxyn[®] 25 mg per day
- Dexedrine[®] IR 60 mg per day
- Dexedrine[®] ER 60 mg per day
- dexmethylphenidate 50 mg per day
- dextroamphetamine IR 60 mg per day
- dextroamphetamine ER 60 mg per day
- DextroStat® 60 mg per day
- FocalinTM 50 mg per day
- Focalin™ XR 50 mg per day
- Metadate® CD 100 mg per day
- Metadate® ER 100 mg per day
- methamphetamine 25 mg per day
- Methylin[®] 100 mg per day
- Methylin[®] ER 100 mg per day

P & T Vote Final Decisions (s) Passed Antihyperkinesis A

9 For

0 Against

Antihyperkinesis Agents will have the following prior authorization criteria:

Diagnosis to Approve via an ICD-9 Override:

Diagnosis	ICD-9
Attention	314.1
Deficit/Hyperreactivity	314.01
Disorder (ADHD)	314.2
	314.8
	314.9
Attention Deficit Disorder	314.00
(ADD)	
Narcolepsy	347.00
	347.01
	347.11
Sleep apnea/hypoapnea	780.57
syndrome	780.51
	780.53
Shift work sleep disorder	307.45

^{**}Agents may be approved for other diagnosis via the prior authorization process based on a review of the current literature by a clinical pharmacist.

Quantity Limits/Maximum Daily Dose

- Adderall® 60 mg per day
- Adderall® XR 60 mg per day
- Concerta[®] 108 mg per day
- Daytrana[™] 30 mg per day
- Desoxyn[®] 25 mg per day
- Dexedrine[®] IR 60 mg per day
- Dexedrine[®] ER 60 mg per day
 dexmethylphenidate 50 mg per day
- dextroamphetamine IR 60 mg per day
- dextroamphetamine ER 60 mg per day
- DextroStat® 60 mg per day
- Focalin[™] 50 mg per day
- FocalinTM XR 50 mg per day
- Metadate® CD 100 mg per day
- Metadate[®] ER 100 mg per day
- methamphetamine 25 mg per day
- Methylin[®] 100 mg per day
 - Methylin® ER 100 mg per day

- methylphenidate IR 100 mg per day
- methylphenidate SR 100 mg per day
- mixed amphetamine salt IR 60 mg per day
- mixed Amphetamine salt ER 60 mg per day
- Nuvigil[®] 150 mg per day
- Procentra[™] 60 mg per day
- Provigil[®] 400 mg per day
- Ritalin[®] 100 mg per day
- Ritalin[®] LA 100 mg per day
- Ritalin[®] SR 100 mg per day
- Strattera[®] 100 mg per day
- VyvanseTM 70 mg per day

Therapeutic Duplication

Prior authorization will be required for more than one long-acting (Adderall® XR, Concerta®, Daytrana™, Desoxyn®, Dexedrine® ER, dextroamphetamine ER, Metadate® CD, Metadate® ER, methamphetamine, Focalin™ XR, Methylin® ER, methylphenidate SR, mixed amphetamine salt ER, Procentra™, Ritalin® LA, Ritalin® SR, Strattera®, Vyvanse™), or more than one short-acting (Adderall®, amphetamine salt combo, Dexedrine® IR, dexmethylphenidate, dextroamphetamine IR, DextroStat®, Focalin™, Methylin®, methylphenidate, mixed amphetamine salt IR, Ritalin®) stimulant at a time.

- methylphenidate IR 100 mg per day
- methylphenidate SR 100 mg per day
- mixed amphetamine salt IR 60 mg per day
- mixed Amphetamine salt ER 60 mg per day
- Nuvigil[®] 150 mg per day
- ProcentraTM 60 mg per day
- Provigil[®] 400 mg per day
- Ritalin[®] 100 mg per day
- Ritalin[®] LA 100 mg per day
- Ritalin® SR 100 mg per day
- Strattera® 100 mg per day
- VyvanseTM 70 mg per day

Therapeutic Duplication

Prior authorization will be required for more than one long-acting (Adderall® XR, Concerta®, Daytrana™, Desoxyn®, Dexedrine® ER, dextroamphetamine ER, Metadate® CD, Metadate® ER, methamphetamine, Focalin™ XR, Methylin® ER, methylphenidate SR, mixed amphetamine salt ER, Procentra™, Ritalin® LA, Ritalin® SR, Strattera®, Vyvanse™), or more than one short-acting (Adderall®, amphetamine salt combo, Dexedrine® IR, dexmethylphenidate, dextroamphetamine IR, DextroStat®, Focalin™, Methylin®, methylphenidate, mixed amphetamine salt IR, Ritalin®) stimulant at a time.

Description of Recommenda	ation	P & T Vote	Final Decisions (s)	
		Passed	Daytrana TM , Methylin [®]	Solution, Methylin®
		9 For	Chewable Tabs, or Procentr	a™ will be approved if
Daytrana TM , Methylin [®] Solu	ution, Methylin [®]	0 Against	either of the following criter	ia are met:
Chewable Tabs, or Proce		_	 Trial and failure of or 	ne preferred product,
approved if either of the follo			which must be the sa	me chemical as the
met:			requested medication	; OR
Trial and failure of on	e preferred		 Inability to swallow/s 	1
product, which must b			tablets/capsules	
chemical as the reques	sted medication:		o For Daytrana	TM, inability to
OR	,			rate PO medications;
 Inability to swallow/to 	olerate PO/whole		OR	,
tablets/capsules	0101000 1 01 1112010		o For Methylin	[®] Solution, Methylin [®]
o For Daytrana ^T	™ inability to			bs, or Procentra TM ,
swallow/tolera				vallow tablets or
medications; (capsules who	I
o For Methylin [®]	Solution.		1	
Methylin [®] Che	ewable Tabs, or			
Procentra TM , i				
swallow table	•			
whole.	•			
Provigil® / Nuvigil® Clinical Criteria		Passed	Provigil [®] (modafinil) / Nuv	rigil® (armodafinil) will
Provigil® (modafinil) / Nuvig	gil [®] (armodafinil)	9 For	be approved if both of the	e following criteria are
will be approved if both		0 Against	met:	
criteria are met:	_		One of the following	ng approvable diagnosis
• One of the follow	wing approvable		(via ICD-9 override)	:
diagnosis (via ICD-9				
	,		Narcolepsy	347.00
Narcolepsy	347.00			347.01
	347.01			347.11
	347.11		Sleep apnea/hypoapnea	780.57
Sleep apnea/hypoapnea	780.57		syndrome	780.51
syndrome	780.51			780.53
	780.53		Shift work sleep disorder	307.45
Shift work sleep disorder	307.45			
Sint work sieep disorder	1307.13		• For Nuvigil® (armod	lafinil) ONLY, trial and
• For Nuvigil® (armodafinil) ONLY,				(modafinil) via a 90 day
trial and failure of Provigil®			look back	incomming the about
(modafinil) via a 90 c			100K Ouck	
(mouainii) via a 90 C	iay IUUK Dack			

Description of Recommendation	P & T Vote	Final Decisions (s)
Corticosteroids, Intranasal	Passed	Selected Preferred Agent (s)
1. DMS to select preferred agent (s) based on	6 For	fluticasone propionate
economic evaluation; however, at least two	2 Against	Nasonex
unique chemical entities, one of which	1 Abstention	Veramyst [®]
must be fluticasone furoate, should be		
preferred.		
2. Agents not selected as preferred will be		
considered non preferred and require PA.		
3. Continue to maintain quantity limits based		
on maximum daily dose.		
4. For any new chemical entity in the		
Corticosteroids, Intranasal class, require a		
PA until reviewed by the P&T Advisory		
Committee.		